SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

NATIONAL ADVISORY COUNCIL

Wednesday,
September 10, 2003

Chevy Chase Ballroom
Embassy Suites Hotel
at the Chevy Chase Pavilion
4300 Military Road, N.W.
Washington, D.C.

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C O N T E N T S

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P R O C E E D I N G S (9:14 a.m.)

MR. CURIE: Good morning, everyone, and welcome back to the second day of our 33rd SAMHSA Advisory Council meeting. Yesterday, we covered a lot of territory. It was a fairly intense day, but I think you got hopefully a good overview of some of the current pertinent issues that are facing SAMHSA.

Today, we're going to be hearing from one of our esteemed council members. Dr. Lewis Gallant in a moment will be sharing on substance abuse issues in the states. As I said yesterday, states is where the action is when it comes to substance abuse service delivery and Lewis represents as the CEO the Association of State Drug and Alcohol Program Directors.

Also this morning, Stephenie Colston, my Special Assistant for Substance Abuse, will be sharing the President's Access to Recovery Initiative, the elements involved with that initiative, the current status. It's something that we heard about yesterday. We're all pressing for the President's budget proposal to be realized of $200 million in '04 for this initiative, and then we move today to the council roundtable discussion that will be facilitated by Pablo and Mark Weber, and we're going to be combining the roundtable discussions from yesterday and today, plus we'll have an opportunity

toward the end for some more public comment from those who are joining us from the public.

With that stated, I'd like to turn it over now to Dr. Hernandez for any opening remarks.

Pablo?

DR. HERNANDEZ: Thank you, Mr. Chair, and welcome and good morning to each and every one of you. I hope that those of you that participated last night on our outing are in the recovering state today. So we are recovering from our experience of last night in Washington. It was a very nice experience, especially Diane's experience.

MS. HOLDER: Don't go there.

(Laughter.)

MS. SULLIVAN: In her defense, we made her take a Metro. That's all it was. She wanted to take a cab.

MS. HOLDER: Only because you dragged me around the city for hours.

(Laughter.)

DR. HERNANDEZ: But indeed, it's a pleasure to be here with you again and we have work to do today and to try to stay within the schedule.

Right now, I think pursuant to that, our schedule does call for us to hear from our distinguished colleague, Dr. Lewis Gallant. Lewis has been an individual that I have

learned to admire and also to love, so I can say that openly. Lewis has always been available to me whenever I have needed any assistance and collaboration in putting things together and under his leadership, I believe that NASADAD has really moved to higher standards. So I just want to say to all of you, may I introduce you again to my friend Lewis and he will let us know what is happening in the world of substance abuse in the states.

Lewis, take it away.

DR. GALLANT: Thanks, Pablo, and I, too, have really grown to respect and love you, too. In going out to Montana, for a country boy, it reminded me of my own experiences. So I felt right at home being out there with very little infrastructure. In my little hometown of 500, when I left, it was Force 99. So population's don't grow very much in small places.

What I want to do this morning is give you some national trends and issues in behavioral health but from a state substance abuse perspective. I don't always like the term "behavioral health," but it's the nomenclature that I think the industry and others have embraced because we know that mental illness and substance use disorders are diseases and they affect behavior, but those of us who are in the field who treat these diseases are treating the behavior and

behavioral health may not be the best nomenclature that we could come up with, but it's what we have and it's what I'll use.

I have a number of trends I'd like to discuss, insurance parity, Institute of Mental Disease, exclusion, the charitable choice, Synar, medications, performance outcome measurement, co-occurring disorders, adolescent treatment, integrating substance abuse treatment in the criminal justice system, alcohol and other drug treatment in response to women, children and their families. Finally some strategies and cost-effectiveness in substance abuse treatment, trauma, natural disasters and terrorism which is a newly engaged activity for us but one that is truly on the top of our list of priorities, reducing stigma by focusing on recovery which I think is something especially important in this day and age, specialized services for older adults.

A lot of folks don't think older adults abuse substances but as a population, they are at the top of our list in terms of those who either abuse prescription medications or illegal drugs, and for those of you who are in my age category, some of the illegal drugs we used back in the '60s and '70s, those folks now are older adults and therefore they have taken those habits with them to their senior years. So folks don't think about that.

Underaged drinking, offender reentry and reintegration, self-help recovery groups as an effective recovery resource, and I won't talk about buprenorphine since Dr. Clark did that yesterday.

Let's talk about insurance parity. It's in almost every state in terms of parity for substance abuse and parity for mental health, but it's unevenly applied. It doesn't have much impact. It doesn't have much effect. Most plans ignore it. So it really doesn't hit the mark and there's no commonality. There's no national standard. There are no real ways that it would provide us true parity. So a national parity plan, I think, would be the best way to achieve true parity for both mental health and for folks with substance abuse disorders.

I think SAMHSA a number of years ago did a study and demonstrated very clearly that by including parity, the costs would be very minimal to most insurance plans, but the benefit would be significant in terms of cost offsets, and so we truly do need as a council to pay attention to that.

We need some Medicaid changes, Medicaid rule changes. The Institute for Mental Disease exclusion which dates back many, many years and was primarily the result of Congress's desire to not see states' culture as from various institutions and to other forms of care for persons with

mental illness. Unfortunately, substance abuse got caught up into that. We have very few institutions in the truest sense as you would find for mental illness and as you would find for developmental disabilities or mental retardation. Fortunately, mental retardation was taken out of that, and IMD does not in fact impact them. Substance abuse was not because historically substance abuse has been viewed as a mental illness and so we got kind of wrapped into that, also.

I think if in fact it was removed, it would be a significant source of new revenue for our system in that most of our residential facilities can't sustain themselves if they have to limit themselves to 16 beds which is the requirement under the IMD. Our facilities really get rolling in terms of cost efficiencies when they're larger than 16 beds. 30-40-50-60 beds is not unusual for a substance abuse residential-type facility. So the IMD clearly represents a concern.

I think CMS, formerly HCFA, thought that there would be significant cost shifting if they removed the IMD. There's no evidence of that, and I think there are ways that we could test it. The Director of CMS, I think, understands that maybe we need to do some modeling and we need to do some testing to see if there are ways by which it could be changed, but before we do that, let's test some strategies and some concepts, and we would certainly, from the substance abuse

community, like to work with CMS and SAMHSA on that.

Charitable choice, another issue, an opportune moment in our mind from the state perspective. States are fully committed to charitable choice. Most state systems have initiatives in place and charitable choice has a long history with the substance abuse field. Our treatment system is steeped in recognizing the value of spirituality and it's a significant component, and we believe that faith organizations bring a lot to the table and can be a significant adjunct to what we already have and what we already do with them, but if they are able to acquire additional funding and revenue could be of even greater service to their communities in a variety of ways.

MS. HUFF: Can you explain exactly what you mean by charitable choice?

DR. GALLANT: Yes. Basically, this is where the faith community would be given a greater opportunity to access federal dollars.

MS. HUFF: So when you say choice, it's by the faith community?

DR. GALLANT: It's by the faith community and it's by the individuals seeking the service.

MS. HUFF: I see. Thank you.

DR. GALLANT: They could seek from charitable

organizations.

Synar. This is an interesting one from the standpoint that I think as you remember, you may recall in Beverly's comments yesterday, Synar as really been successful in terms of reducing youth access to tobacco products from a selling standpoint. We don't necessarily know if it has really reduced youth smoking, but at least retailers have declined in terms of selling to youth. It's an unfunded mandate for states. We don't get any additional resources to do what we've been asked to do and basically what we've been asked to do is to, by the year 2000, we had to reduce youth access in every state by 80 percent basically and that's a fairly lofty requirement, particularly for an organization or an entity within the state that has no enforcement authority.

There are very few, if any, substance abuse authority with any law enforcement assets. So in order to enforce the Synar requirement, state substance abuse authorities have to borrow, beg, buy, steal, whatever the enforcement needed to help implement the enforcement side of Synar.

Now, there is a federal entity with responsibility for reducing youth and adult smoking and that's the CDC, the Centers for Disease Control and Prevention. They have a clear mission statement that says it is their job to

reduce smoking, underaged smoking and smoking by adults. They have that in their mission statement. They have funded for many years tobacco control initiatives within departments of health in states, and most state departments of health have a tobacco control activity and the purpose of that activity is to reduce both youth and adolescent smoking. So it is our belief that there are better ways to achieve that and we would hope that we could work with SAMHSA to make that happen.

Medications. Again, I think Dr. Clark did a very nice job yesterday of telling us how medications are becoming a major part of our treatment milieu. One of the concerns we have with medications is that our programs historically have been drug-free programs and that means all kinds of drugs. If you come in with medications for a medical condition, many of our programs had a lot of problems with that. We have slowly matured and recognized the value of having medication as an adjunct to treatment, but it is still an issue.

Paying for medications. We haven't historically paid for medications and therefore that's another cost that we would have to bear, and if you look at what happens on the mental health side and on the primary health side, medication is one of the most frequently cited costs in terms of overall increases within those systems. So we have to recognize that that is an issue and we'll have to be concerned with that.

Impact on infrastructure. When you start dispensing medications, you have to have physicians oftentimes. You have to nurse-practitioners to administer the medications. So that's again another cost that we need to consider, and then the impact on the workforce. You then have to bring different kind of people into your program in order to ensure that the medications are appropriately administered.

Performance outcome measurement. Again an issue that is looming for us. I think this is driven by changing financing models. Payers are now involved in setting and monitoring standards which is rightfully so. Our federal partner has worked with us over the last few years to help us develop those monitoring standards and that's good. The care system's become market-driven, basically, and those who cannot perform get, I guess, run out of business and those who achieve good results stay in business. That's a good thing because we do have providers who aren't necessarily the best and to have some mechanism whereby we can weed those out is clearly an enhancement to our overall effort. We need to also recognize that there are multiple customers that we attend to.

As an example, in the criminal justice system, we have in my opinion two customers. We have the public safety system and we have the consumer, but the public health model usually values the consumer and that doesn't set well with the

criminal justice system because their job is to keep that criminal from reoffending and having any contact with society at large until they complete their sentence, and so when that person comes into treatment and they want to know if he or she is still using and the counsel says, well, you know, because of confidentiality, I can't tell you, that doesn't set very well with them.

So we have to recognize that maybe the first customer in the criminal justice system is in fact the criminal justice system and the offender is the second customer, and so those are issues that the system really needs to grapple with as we attempt to embrace and get involved with those.

Co-occurring disorders. We've heard a lot about that. We are fully committed to providing services to to co-occurring to individuals who have both a substance abuse disorder and another co-occurring issue, but in addition to mental health, we have a variety of co-occurring things that occur with our population. They oftentimes are engaged with the criminal justice system. They're engaged with the child welfare system. They are involved with social services, with TANF and so forth. They're involved with the education system, and all those systems usually are asking that we provide some level of effort to help them with their

particular populations.

Adolescent treatment. Less than one-tenth of adolescents with substance abuse dependence problems receive treatment. Small number. Under 50 percent stay six weeks, 75 percent stay less than three months in treatment as recommended by NIDA, and from '92 to '98, we had a growth from 96,000 to a little over 150,000 in terms of treatment and then we dropped off again, and again I think that may have been due to changes in financing, insurance programs, getting rid of that benefit, but there may be a variety of factors, but it's an area that we clearly need to be concerned about.

Integrating substance abuse treatment to the criminal justice system, an issue that again we have to pay attention to. Right now, we have 1.8 million inmates in the U.S. in jails and prisons. This was for 1999-98. Drug offenses are the leading cause of these increases. Approximately two out of three arrestees have drugs in their urine and approximately two out of three inmates admit drug histories but under 15 percent receives systematic treatment in prison.

We need to really think about giving treatment while the person is in prison and then setting up a system as they exit prison, we can reengage with them and provide them some sort of transitional aftercare, so that we don't lose the

gain that we achieved while they were in a TC, a therapeutic environment, within the criminal justice system, and it's cost effective.

We know some of the practices we've had in the past aren't very effective. We know boot camps really don't demonstrate good outcomes. We know that using drugs does in fact show promise in those, using methadone and buprenorphine in those situations. We know that selected educational 12-step cognitive behavioral therapies show promise in those programs, and we know that we need to do risk assessments to drive what we do, and I think we've also found that in the mental health system in terms of how we categorize persons we interact with. Do risk assessments to sort of stage who gets what when.

Offender reentry and reintegration. I think that most people don't think about but we have a lot of folk preparole being eliminated that are in prison that are coming home, and if they didn't get anything in prison, whatever they took with them, they're going to bring back home, and unless we have some methodology by which we can engage those individuals as they reenter their communities, we're going to find ourselves not really having achieved very much, and in 2000, more than 630,000 offenders reentered their communities and the numbers are expected to just increase and not decrease

at this point.

Self-help groups. An effective recovery resource, and I think our particular field has valued and we understand the value of using recovery resources. Alcoholics Anonymous, Narcotics Anonymous, Secular Organization for Sobriety, Women for Sobriety, Modification Management. All of these are recovery resources that enable us to have adjunctive support for what we do in the normal course of treatment, and it's something that we need to really value and grow, and I think as we heard yesterday about Oxford House, it's a model that is low cost but high value, but we don't value it as much as we should, and I think we need to pay a little more attention to that.

Financing strategies and cost-effectiveness in substance abuse treatment. The Medicaid option, I think, is one that we need to continually review. It's not a good time now because most state systems don't have the match to draw down additional Medicaid and so if you open up the plans for substance abuse, it wouldn't be the most opportune moment to do that, but it's something, if in fact we have an upturn in our economy, we should put on the table again.

SCHIP, or the State Children's Health Insurance Program. Again, it's not a good time but again it's something we need to continually pursue as a way to enhance services to

populations.

Substance abuse treatment as a cost offset. It's hard to help politicians understand the value of providing treatment early because they want to see the change within their term in office. So if they can't see the offset in the two to four years they're in office, it doesn't matter. But we know that hypertension, we know that cirrhosis of the liver, we know that a lot of diseases that in the out years when people abuse substances are directly related to their use of alcohol or other drugs, and so if you provide that treatment early, then those costs where you end up spending $200,000 or $300,000 for a new heart or $100,000 for a new liver transplant or whatever, you could avoid those costs by providing treatment early on, but again it's hard for legislators to understand and accept those costs.

Developing funding memorandums with other payers, like TANF, child welfare, public safety. That's another way to increase our ability to get costs in line.

Trauma and natural disaster and terrorism. I think as Charlie found when he first came into his position, it was something we had paid some attention to but found at that point we needed to pay a lot of attention to, and particularly for first responders and particularly for substance abuse, delay in onset is very likely. So it may be

six months or longer before you begin to see the results of the trauma in people who enter your system of care or enter the system of care.

Reducing stigma by focusing on recovery. Again, we need to engage and develop the recovery community. We need to rethink anonymity. Now it's not that much of an issue for mental health, but for substance abuse, our history has been steeped in don't talk about it, don't tell that you are in recovery, don't tell that you achieved recovery, don't talk about it. As a result, we don't have any advocacy mechanism. The only advocates we have are guys like me who earn their living by being in the field and that doesn't set well when you go before Congress. I have a vested interest to make things happen because I want to get paid, but if I have a consumer or a family member go before Congress or state legislature and talk about what they've experienced and achieved and how treatment helped them, it means a whole lot, but we don't have that population because we have again steeped ourselves in anonymity and it has nothing to do with confidentiality. We just have a history of saying don't talk about it. So we need to take a real strong look at that.

Specialized services for older adults I think I've pretty much hit on. It's something we don't attend to and something that I think the Council truly needs to take

another look at it and pay some additional attention to that.

Underaged drinking. Again, it's an initiative that's kind of all over the place. I got a call last week from someone who wanted to develop a media campaign around underaged drinking, and I said, "Well, have you talked to this group? Have you talked to that group? No. No." It's just not something that a lot of people know about or at least are paying the level of attention to that they should, and so I think that's something the Council should in fact take a look at.

So those are the major issues and trends that I believe are important and that I feel and have identified as important, and I would hope that as the Council continues to deliberate and plan its work plan for the upcoming year, that you would take into consideration those issues and try to work with Charlie and his administration or his staff to deal with some of those.

So thank you very much.

DR. HERNANDEZ: Thank you, Dr. Gallant.

(Applause.)

DR. HERNANDEZ: Any discussion from the Council and comments?

Kathleen, please.

MS. SULLIVAN: Good morning. Thank you very

much.

I was really hit by something you said and this gets into the old faith-based initiative every time we start discussing this, and I'm trying to find the exact verbiage that you said and you had such a great line, Lewis. See what happens in old age, you take off your glasses. I am starting to get concerned because you said, "The state systems are fully committed to charitable choice and they're steeped in the component of spirituality."

Can you discuss and explain to me a little bit more about your feelings about the separation of church and state and all of this preceding? As we get closer and closer to merging and seem to benefit, as Alcoholics Anonymous is very steeped in its 12-step programs of spirituality and as all of the substance abuse field, and I think as the mental health field is now starting to approach the understanding and benefits of spirituality.

As we start approaching government sponsorship and government dollars going into funding programs that speak of God, so to preclude any ACLU brief, what are your feelings as we approach and go down what is, I see, a very, very tip-toey path?

DR. GALLANT: Well, you know, I think we have evidence that there are ways by which you can achieve the

involvement of the faith community without necessarily stepping on the separation of church and state issue. I think we have Catholic Charities. We have other organizations that have a religious history that have been able to maintain their allegiance to faith and to provide charitable services and to receive federal and other resources without stepping on that.

We just need to kind of figure it out to make sure that happens, and I think we also need to ensure that there are safety considerations built into these things whereas providers from the faith community must be licensed or certified or must meet state requirements for the delivery of that service. I think they can set up separate 501(c)(3)s that would allow them to separate and not co-mingle their resources which might in fact handle some of that.

So I think there are models that we have created over the years that would allow us to deal with the issue of separation of church and state, but it has to be thought through, and I would rather not put myself in the position of trying to say what that is.

MS. SULLIVAN: Lewis, who's doing it?

DR. GALLANT: Well, I think there are a variety of entities that are carefully analyzing this particular issue, and I would assume at some point that we'll come to some level of resolution where we can continue to do what we

have historically done with Catholic Charities and other religious organizations who have wanted and who are providing adjunct services. But I think it needs to be a public dialogue and people need to come to terms with whatever the final solution is.

MR. CURIE: What I would add to what Lewis has said, because I think he highlighted very well the issues around it, when it comes to separation of church and state, if you look at the charitable choice regs themselves and what we are looking at in the regulations, we carefully state that there needs to be a level playing field for providers to be able to come and be eligible for appropriate funding. Also that we recognize the wide range of religions. It's not just one religion in terms of separation of church and state.

The other issue is if you keep focused on outcomes, in other words, if you keep focused on quality standards that Lewis was talking about, transparency in terms of mission, and I think the thing to keep in mind is that there have been faith-based organizations who have received government funding for years and examine those models and be focused then on outcome.

It's not a matter of identifying effective religions. It's a matter of purchasing clear outcomes in people's lives, and I think keeping the focus on the issue of

outcome standards, transparency, and the regs that articulate that and I couldn't agree more with Lewis, I think there needs to be an open dialogue about this as we continue to clarify and move in the direction of acknowledging many pathways to recovery.

I think when you look at the substance abuse field in particular and you, Kathleen, again I think articulated well, when you talk about AA, talk about the 12-step program, there's always been the element of spirituality that's part of that, and I think the key is not to be defining one kind of religion or faith but the key is recognizing a level playing field for the various pathways of recovery is another aspect of this.

DR. HERNANDEZ: Mr. Slack.

MR. SLACK: I think of all the statistics that you've presented, the one that jumped out to me was the one where 15 percent of people in prisons do not receive systematic treatment, and I'm wondering if you could elaborate on why that's the case.

DR. GALLANT: Well, you have to recognize that in correctional settings, the primary goal of that institution is to do three things: safety, security and sanitation, and it is not to necessarily provide other services. Once those three things are done, most correctional authorities are very

open to a variety of things, but they don't necessarily have the resources to support it.

The substance abuse field has been very open in terms of going in and making themselves available. Other allied health services have not necessarily been so willing to go in without financial reimbursements. So that's part of the reason.

Secondly, it's a recent phenomenon, and I think if you look at what the growth in health expenditures within states, particularly as relates to substance abuse in particular, most of those resources of late have been going to the criminal justice system because legislatures have recognized that if you provide the treatment early and you give them good aftercare, that you can reduce recidivism, you can reduce reoffending, and many correctional leaders recognize that it's a good management tool. The most orderly pods in most jails are those that have a TC and those are the pods that the jailers want to work on because the inmates are the best behaved, they're the best managed, and so forth.

So the number has been an historical artifact of allied health professions not wanting to go into jails and jailers not necessarily early on seeing the value of providing that kind of adjunctive care.

MR. SLACK: Another observation that I've made

visiting different states is that the Department of Corrections and the Department of Mental Health seem to quarrel over who's responsible for providing some of that mental health care.

Would the Departments of Mental Health who may have more expertise in this area be better at providing those services within the correctional facilities? Because it seems like the correctional facilities are focused on the three S's that you said.

DR. GALLANT: Right. Well, you're probably right, and I'll let my mental health colleague deal with the mental health piece, but yes, I think we would be. As I used to tell folks back in Virginia when I was state director there, I don't build jails, they shouldn't build treatment programs. We have the capacity. We have at least the expertise to set standards and to go into those institutions and provide them with solid treatment without them having to create their own system of care in order to do that.

So I think in the substance abuse area, we do outreach and I like to say that we don't ration care in the substance abuse treatment system. Whatever you bring to the table and if we have the resources to take you in, we will. Now that's not necessarily the case with other allied health entities because they do ration care and so they kind of

prioritize the populations they let in, and I think that may be what you are experiencing when you go to these facilities and you find that the mental health folks or the primary health folks say, well, you know, it's not or job or we don't have the resources. Maybe they don't have the resources, but our system has been one where we give until we don't have anything else to give and we don't have a lot to give.

DR. HERNANDEZ: We thank you, Dr. Gallant, and I think in view of the time, I think we need to move on, and I would like to go ahead. We have more time for the council discussions later on.

May I turn the meeting over to our chair, Mr. Curie.

MR. CURIE: Thank you, Pablo, and again thank you, Lewis, for that very informative and comprehensive presentation.

It's my pleasure now to introduce to you Stephenie Colston. Stephenie is special assistant to me for substance abuse issues and Stephenie has a strong in-depth background in both the drug and alcohol arena. Most recently in the last several years that's been her focus, has been substance abuse. She also early on had a background in mental health as well. She's been a provider on the front lines. She's been a very able consultant. I know she's worked

closely with state drug and alcohol authorities through the years.

When she came aboard, the bench was greatly deepened in terms of the Office of the Administrator when it comes to substance abuse treatment and prevention arenas, and she's invaluable to me and has been the point person working on the President's Access to Recovery Initiative. In particular, she and Westley Clark have co-chaired the committee that's developing the Request for Applications standards that will be going out to the states and that's been a process where she's engaged stakeholders in the substance abuse field, trying to forge new territory.

As you know, Access to Recovery involves vouchers as a financing mechanism which is relatively new and profound, though she has been able to find voucher programs around the country to serve as models and to learn from those experiences, and it's also for the first time acknowledging there are many pathways to recovery, trying to formalize that, that there is not just one certain treatment protocol regime and translating that is a challenge, but I know Stephenie's been up to it and she's here today to share with you Access to Recovery, the initiative and the current status.

Stephenie?

MS. COLSTON: Thank you, Charlie. What I'd like

to do is just update some of the information that you already have and then be happy to answer any questions, and in your notebooks, I think Tab H is kind of a fact sheet that talks about how we envision that the ATR, I'm going to call it ATR, initiative would work.

So I'm going to talk a little bit about and repeat some of the information in that sheet and then talk about the process that we've used to develop the Request for Application, which being a dutiful federal employee, I was telling Jim Stone the other day, now I just speak in acronyms. I don't know that that's a good sign but it's real.

At the State of the Union Address, President Bush announced a three-year $600 million federal treatment initiative, Access to Recovery. ATR will assist more Americans who need critical recovery services, complementing existing substance abuse treatment programs, and increasing treatment capacity and consumer choice. ATR also will accelerate the President's pledge to heal American substance abusers by increasing treatment funding by $1.6 billion over five years which is a commitment that the President made when he came into office.

As Mr. Curie mentioned, ATR will utilize vouchers for the purchase of substance abuse treatment and recovery support services. It's hard to explain what a revolutionary

concept this is in terms of health care financing and delivery. It really attempts to put the dollars in the hands of the consumer who can choose the provider, whether that provider is nonprofit, community-based, proprietary, or faith-based, that can best meet his or her needs. The voucher program will clearly help us facilitate recovery in new ways, as Mr. Curie mentioned, and help an even greater number of people who suffer from substance abuse disorders to obtain that life in the community that drives SAMHSA's everyday work.

ATR allows us to accomplish several objectives but three in particular. One, acknowledging that there are many pathways to recovery, as Mr. Curie just mentioned. The voucher mechanism allows recovery to be pursued in an individualized way, providing consumer choice which we feel is the epitome of accountability. The process of recovery, as many of you know, is a very personal one. Achieving recovery can take many pathways, whether it's physical, whether it's mental, whether it's emotional or spiritual. Increased choice protects individuals and encourages quality.

Number 2. It's results-oriented. The ATR program will reward performance. SAMHSA's been working with states and the fields to establish measurable outcomes for more years than I can count. We've identified for the Access to Recovery Initiative seven outcomes domains that capture the

outcomes which demonstrate patient success. Mr. Curie calls them measures of recovery. They are as follows: no drug and alcohol use, no involvement with the criminal justice system, securing employment, social support system, living situation, access to care, and retention in care.

These domains, when finalized, will be aligned with our Performance Partnership Block Grants and ultimately they will become the same ones used across all of our programs. It just makes sense to use consistent measures across programs that have the main goal of building resilience and facilitating recovery.

Third. The initiative will increase capacity. ATR will increase treatment capacity by expanding access and the array of support services that are critical to recovery, such as medical detox, inpatient/outpatient treatment modalities, residential services, peer support, relapse prevention, case management, and other services.

SAMHSA plans to issue, I mentioned earlier, a Request for Application, an RFA, once Congress approves our '04 budget. All states will be eligible to apply. Governors' offices will be eligible to apply for funds because governors are key to ensuring a coordinated approach across all the state agencies, such as state alcohol and drug authorities, state mental health authorities, state child welfare

authorities, Medicaid, CJ, all of those entities, state entities that come into contact with people with addictive disorders.

States that choose to participate and this will be competitive will be largely responsible for developing most of the details. They'll be able to tailor their application to meet their particular needs and they'll have considerable flexibility to design the type of voucher system that's appropriate for their state. States will be required to supplement and not supplant current funding which is very important. That way, we can truly expand capacity and the array of services available.

States will be expected to establish a process for screening assessment, referral and placement for treatment and support services that's appropriate for the individual client. Clients will be assessed, will be given a voucher for the appropriate level of care and then will be referred to a variety of providers who can offer that level of care. As initially contemplated, the voucher will have no face value.

We anticipate that successful state applicants will establish the following. Need, based on data on rates of abuse and dependence, documentation of the most feasible approach consistent with the voucher program's guiding principles, eligibility criteria for providers and for

clients, criteria for matching clients with the appropriate treatment, standard costs and reimbursement for treatment modalities, and last but certainly not least, creative approaches to address those with special needs. For example, homeless populations, co-occurring populations, persons living in rural areas, adolescents, children.

We are aware that states will need our help in implementing Access to Recovery and Mr. Curie has committed an additional $11.5 million, additional is the key word there, for immediate state technical assistance for planning and implementing Access to Recovery.

Lastly, I just want to talk a little bit about process for developing the RFA. We are in the final stages of that and just want to bring you all up to date about it, then I'll be happy to answer any questions. Mr. Curie created a structure to guide the Access to Recovery RFA development. An executive steering committee was created to provide overall policy guidance and consists of representatives from the Office of the Secretary for HHS, the Office of the Assistant Secretary for Budget, Technology, and Finance of HHS, the following White House offices: the Office of National Drug Control Policy, the Office of Management and Budget, the Domestic Policy Council, and the Office of Faith- and Community-Based Initiatives, and last but not least, the

SAMHSA Office of the Administrator.

As Mr. Curie mentioned earlier, a voucher implementation workgroup which is an internal SAMHSA group has been meeting almost weekly, I'd say certainly biweekly, since February and is finalizing a draft RFA which we anticipate will go to the executive steering committee this week. Four groups from the field have worked with us to develop this RFA, and for each of the four groups I'm going to talk about, we had representatives from a currently funded provider, a single-state authority, a technical expert, if you will, and a faith-based organization, and the four groups met to identify appropriate standards for the RFA, to identify appropriate performance measures for the RFA, to identify cost and reimbursement ranges, and to identify assessment and placement instruments.

To summarize, as Mr. Curie said, Access to Recovery represents a unique opportunity for us to create profound change in the financing and delivery of substance abuse treatment services. It also represents this year's only chance to infuse new substance abuse treatment dollars into fiscally hard-pressed states and that's a very, very important point.

I'm happy to answer any questions that anyone has.

MR. CURIE: Any questions? Barbara?

MS. HUFF: I'm not as nice as Lewis. He's a nice advocate. Maybe it's my own personal experience in not being able to get what I needed for my own daughter, but I have no faith that people will do the right thing when it comes to kids, and I'm fearful, terribly fearful that if we don't spell out the right for states to use this money for adolescents as well really, really clearly, then it won't happen.

It doesn't sound like there's nothing that would prohibit them from doing it, right?

MS. COLSTON: Correct.

MS. HUFF: But when we talk about people, we just automatically think about adults and not young people, and I just am very fearful and worried that if we don't spell that out, to say that it's okay for them to use the money on adolescents as well, that it won't be and that's my biggest concern about this money, is that the kids get a shake at this.

MR. CURIE: Again, we're going to be identifying populations. We could clearly consider this in terms of in the point structure.

MS. HUFF: We don't have to think about kids as a special population, though, do we?

MR. CURIE: Well, to get at what you're talking

about, if you really want to make sure it's highlighted.

MS. HUFF: Do you think it would be better as special populations?

MR. CURIE: In general. I mean, what you're saying is if we want to make sure adolescents get a fair shake in this, what we need to consider in the structure of the RFA is is there a way that that can be recognized in the point system and that type of thing. I mean, that's concrete --

MS. HUFF: So they would get extra points then if it was a special population?

MR. CURIE: That's the type of thing we're examining, yes.

MS. COLSTON: Actually, what I was reading was what will most likely be the award criteria and that category of creative approaches to address those with special needs.

MS. HUFF: Spell it out as far as you can get it for people.

MS. COLSTON: Got it.

MS. HUFF: They just don't get it. I wish they did.

MR. CURIE: Well, the one thing about the Access to Recovery, we are looking to set broad standards and give states some latitude because needs vary from state to state. I think Lew's going to attest to this. We also want to make

sure Access to Recovery is consistent with the state plan for drug and alcohol treatment services.

We also want the states to be creative in terms of expanding capacity. For example, some state may take this as an opportunity to expand capacity to adolescents and they may not do it directly by using the voucher. They may implement the voucher program in an urban area where there's a lot of competition, where they can stimulate more competition, where there's a lot of resource and target to a more rural area adolescent services where there's been hardly any services in the past and use some of the current funding that has funded things in the urban area in the rural areas. One example.

So it's not necessarily that the only expansion in capacity is going to be realized directly where the voucher's being implemented, but a state's going to be able to demonstrate expansion of capacity and also addressing the needs of the underserved population by perhaps an offset of where they're shifting resources in combination with where they're implementing the voucher program. I mean, there are many ways a state will be able to demonstrate that.

MS. HUFF: Do states have to mention it now, Charlie, in their state plan? Do they have to mention how they serve adolescents or not?

MR. CURIE: I'm not sure that that's a specific requirement of it.

MS. COLSTON: The substance abuse block grant does not require a plan at this point.

MS. HUFF: I was just curious.

MR. CURIE: On the mental health side, there is a state plan. Lewis might be able to speak to this from his membership, but it varies from state to state any level of a formalized plan that they may have.

MS. HUFF: Okay.

DR. GALLANT: You know, I think you need to recall that what we have here in terms of the current substance abuse treatment delivery system has been basically oriented towards adults historically.

MS. HUFF: Right. I'm trying to change that. One-person crew.

DR. GALLANT: We have recognized that adolescent treatment is an important thing that we need to pay attention to and I think most states have done that and are doing that.

MS. HUFF: Thanks. And I did mean that about you're my role model, Lewis, in being nice.

MR. CURIE: Do you need to spend more time with Lewis?

(Laughter.)

MS. HUFF: I'm thinking about it.

MR. CURIE: Pablo. Pablo, and then Gwynn.

DR. HERNANDEZ: Thank you, Mr. Curie. I really appreciate Ms. Stephenie walking us through this as well as your leadership in the Access to Recovery, and I can only think that this might be one of the best opportunities that minority populations will have a choice. I think too often, we are not able to access care appropriately because the providers that are established are providers that we don't trust, and I think this might give us an opportunity to expand the avenues of voting with our voucher just like voting with our feet where we can go wherever we want and receive whatever's appropriate.

I just encourage you, Mr. Curie, to look at this also in terms of moving the agenda to mental health. I think it is crucial that if we can learn from this Access to Recovery on Substance Abuse, that we can tailor after our colleagues in the substance abuse and then see where can we go with mental health and recovery. This would be a great opportunity for us to do so.

MR. CURIE: Thank you, Pablo. Obviously we're going to be learning a lot of lessons in terms of the implementation of this program and we're learning a lot from the models that are out there, and I think facilitation of

choice is something that, as you've said, has not been realized and so clearly appreciate that comment.

Gwynn?

MS. DIETER: Yes. First of all, thank you, Stephenie. This is really exciting and it sounds like you're just moving right along, and my question as I'm just sitting here thinking of the last criterion of creativity and using these funds, is it possible in any way that -- I know it's vouchers, but that it could address the criminal justice population? Of course, there choices are limited because they're in prison, and I don't know if you really want to go in that direction.

Anyway, it just came to mind, is that possible, that a state could use --

MR. CURIE: Not in prison, no. Again in our relationship we're developing with Justice, Justice has historically, and I think it's appropriate, been responsible for funding treatment within the walls of the prison. However, it's critical for us to be linked in partnership to help fund -- nothing precludes us using the vouchers in diversion programs, for example, in conjunction with the drug courts.

MS. DIETER: Right.

MR. CURIE: If the services are provided in the

community as well as reentry programs as individuals are coming out of the prisons. So the answer is yes and no. The answer is yes, we can use it in conjunction with criminal justice, and in fact, to give you another example, nothing precludes a state from submitting an application at this point as we're conceiving of this, if they want to use the voucher program primarily in drug court scenarios as a way to get started and that is how they're expanded, as long as they're ensuring that they're expanding capacity in the overall system of treatment or care. That's one reason we're giving the states latitude. They may be able to determine where they can best meet pent-up demand and need. It might free up some resources that are funding some drug court things now to be used other places, too, and still show an expansion of capacity.

We are going to be taking very seriously this issue of supplementing, not supplanting, and a state's going to have to demonstrate that they aren't just supplanting cuts or other things in the drug and alcohol field, but as long as they can demonstrate they truly are overall expanding capacity, it can be linked but not to treatment within the walls.

MS. DIETER: Right, right. But with the diversion or reentry?

MR. CURIE: Right.

MS. DIETER: Okay. Thank you.

MR. CURIE: Daryl? I'd like to ask her to comment, going back to Pablo's comment around choice. Would you want to update us on the self-determination?

MS. KADE: Sure. As you know, the SAMHSA matrix included NFI and now mental health transformation as a program priority category, and prior to the report, the NFI principle of self-determination was something that SAMHSA was embracing and wanted to pilot based on some of the models that CMS had developed for all their disability groups, and the concept there was that the funding follows the client and not directly to the provider and that's also a recommendation in the Mental Health Commission report. So we'll be pursuing that and you can see how those two are coming together with the vouchers and with the self-determination.

DR. HERNANDEZ: You know, I very much appreciate that because I think that's crucial, that too often we have developed systems that are just kind of like a big funnel with a big mouth and then a little hole at the end and everybody fits there. Well, that didn't come out the way I wanted.

(Laughter.)

DR. HERNANDEZ: But again, I think if we are really going to be a client/family-driven client center, we've

got to go to the choice more and more, I think. Often, we talk about access. The one thing I see is retention to care. I think we may access care. The difference is retention to care and retention in care, that is crucial. So I think having a choice of opportunity will have providers to be more consumer and family centered in every way that we can think of and this is a plus. This will be a major transformation. So we want to say SAMHSA, thank you for keeping that up.

MR. CURIE: Thank you, Pablo. Any other questions or comments to Stephenie's presentation?

(No response.)

MR. CURIE: If not, thank you, Stephenie.

(Applause.)

MR. CURIE: Before I turn the chair over to Pablo again, one person that's not been recognized who has sat at the table but he kind of snuck in yesterday late, he's here today, is Rich Kopanda. Rich is the individual who's subbing for Westley Clark today. He is the Deputy Director for the Center for Substance Abuse Treatment and we're pleased to have you here, Rich.

MR. KOPANDA: Thank you.

MR. CURIE: Keep your eye on him, Kathleen. Thank you.

Pablo?

DR. HERNANDEZ: Thank you, Mr. Chair.

I would like to invite to the table our distinguished colleague Mark. Where is Mark Weber? There's a couple items that I would like to have for the Council consideration. Number 1. We started yesterday visiting the issue of upcoming meetings. So we need to have Toian be ready for us and the question is were you able to look at your schedules for the month of December? Yesterday was a dialogue about December 11th and the 12th. That was one date that we put on the table. How does that fit? Those able to participate on December 11th and 12th?

(Show of hands.)

DR. HERNANDEZ: Okay. Well, it seems like we will work toward December 11th and the 12th. Definitely we would love for you to be able to look at your schedules when you go home and if you can provide Toian with dates that would be appropriate for the following month probably, we might be looking at March 2004. Is that what we're looking at, Toian?

MS. VAUGHN: March or April.

DR. HERNANDEZ: March or April 2004, and then would we do May or we probably would do July, no?

MS. VAUGHN: We're going to have two meetings and we've already talked to some of you about your schedules and some of you we're still waiting to hear back from you. Based

upon that and based upon Mr. Curie's and Mr. Stone's schedule and Daryl's schedule, then we'll try to lock in a date, but what we're looking at now and we're asking the hotel if they have available for December and we're looking at the 10th, 11th and 12th to give us some flexibility, even though I'm aware that you're interested in December 11th and 12th.

Then with regard to March and April, we have to take into consideration the budget and those particular activities, but we will work around March or April and it may be May, but you're going to have two meetings next year.

DR. HERNANDEZ: Very good. So you can submit that to Toian and we appreciate it.

At the last council meeting, we did pass a resolution that we were going to be submitting to Mr. Curie having to do with the science-to-service initiative. You all remember that? You have that in your book as a draft and it's under Tab I-2, and we tried to capture each and every one of your thoughts at that particular time and this is the resolution that we have come up as a draft right now and if you will take a minute or if you have read it already, we would like very much your comments so we can move it up to the formal presentation to Mr. Curie in the matter that is prescribed.

Diane. I think Diane has visited that issue.

MS. HOLDER: Yes. I think this is one of the most important initiatives that we need to push and I know that the leadership in SAMHSA is very interested and committed to making this happen, and I think part of the struggle will be getting the other colleagues in the other sectors to really put the kind of commitment behind this so that any kind of strategies I think SAMHSA can come up with increases the odds that NIDA and NIMH and the other groups will really come to the table in a truly meaningful way will be critical. So in any way that I can help on that or I'm sure other council members, that would be, I think, very exciting and important.

DR. HERNANDEZ: Thank you, Diane.

Any other comments about the resolution?

(No response.)

DR. HERNANDEZ: We tried to draft as much as we thought that your language of the last meeting was guiding us. We submitted this previously and we did receive feedback from some of the members of the Council giving us guidance. Dr. Maxwell gave us guidance, Dieter, Diane, others. So again, we're still able to take any other suggestions or we can just go ahead and make a decision about submitting this to Mr. Curie.

(No response.)

DR. HERNANDEZ: Well, thank you very much. I

know that you may have not any comments about it. If this is okay for everyone or we may require a little more time to read it. Well, why don't we just go on with the meeting and then in between thoughts, you can read a little bit about it. So we want to stay on schedule.

So we would like now to invite our distinguished colleague Mark Weber to participate with us, but before we get there, we also have another item of importance which is the approval of the minutes of our last meeting. We have not done so. So I know that you have read the minutes, and I would like for you to consider that I will entertain a motion to accept the minutes, if that is your desire.

PARTICIPANT: So moved.

PARTICIPANT: Second.

DR. HERNANDEZ: Okay. There's a move and there's a second. Any objections?

(No response.)

DR. HERNANDEZ: All those in favor, please say aye.

(Chorus of ayes.)

DR. HERNANDEZ: Opposed, same sign.

(No response.)

DR. HERNANDEZ: Unanimously, the minutes of the April 24th-25th Council have been moved and approved by the

Council.

Now we're open for Mr. Weber. Please, if you can guide us through the process of the ambassadorship and the thoughts and ideas that the Council has had in reference of their desire to participate more intensively with SAMHSA as representatives or colleagues or ambassadors.

MR. WEBER: Thank you. Thank you. You kept leading me up there a couple times.

(Laughter.)

DR. HERNANDEZ: We just want to keep you in suspense. I noticed that you were --

MR. WEBER: I live waiting for the other shoe to drop.

Anyway, thank you. I truly appreciate it. I like working with Pablo. Anyway, last time we met, we talked about some of the ways that we can increase the involvement of the SAMHSA Council in the day-to-day activities of SAMHSA, so that the only time you're not hearing from us is when you come to Washington and we have these intensive meetings for a day and a half.

One of the things we committed to doing last time was to do a survey of the council members to in particular look at the areas of interest that they had, and we conducted the survey and Toian has sent it over to me and one of the

things we're trying to do with that survey is when we have an announcement or something coming up that possibly we can match the advisory council member and give them some advance notice about what's happening.

Two things that we have going already that are an example, but not quite exactly lined up with the survey but all coming together at the same time, is, for example, Pablo is going to be speaking at the National Latino Behavioral Health Conference in L.A. next week, I think, and as a result of working with Pablo, we're providing him with copies of the matrix and again he's going to be going and not only representing Pablo but representing SAMHSA as the co-chair of the SAMHSA Advisory Council.

We've also worked with Kathleen as a result of a little bit of behind-the-scenes talking. She's going to be speaking at the Henz Proctor Annual Dinner in Detroit, Michigan, in, let's see, about a month, and we have a couple other little things. Again, it's just keeping on hand that list of things that you are interested in and lining it up and often you all have your own annual meetings and making sure that Charlie's there or someone from any of the centers are there.

I always hesitate when I say things because three-quarters of the room raises their hand and says it's not

true, but you all should be getting the weekly report on a weekly basis. That is the way I track what's going on at SAMHSA. The good news is that's what we know about. The bad news is the things that we don't know about that doesn't get on there, and I'm sorry Jane Maxwell isn't here, but Jane was rather adamant with me about making sure that the weekly report was done in Word because so many people are having problems opening WordPerfect and Toian couldn't convert it, and I was just like okay, I'm sick of this. So all of SAMHSA got an e-mail about a month ago or so saying you will submit it in Word. So again, it's just that feedback. If Jane had felt I'm not going to tell, you know, but being Jane, she let me know. So the weekly reports are now done in Word SAMHSA-wide and submitted to the Department that way as well.

Again as an example, Jane is very interested in the issue of inhalants and we're starting to line up a press conference we're going to be doing on inhalants in March. So already sort of thinking about lining those kinds of things up.

Another thing we did recently is the Drug Abuse Warning Network and, of course, one of the neat things about DAWN is we oversample in 21 different cities across the country. So in addition to sending you the national press release, we tried to line up with the local area that you're

coming from the data from your city, and I know, believe me I know, Kathleen is on the phone and the e-mail all the time trying to get press coverage and pushing these issues, and in fact, we use some of her contacts in radio last time Charlie was in L.A. to set up an interview on seclusion and restraint. So it's always nice to not only have Charlie go give a speech but also use the opportunity to be in town and then get some radio coverage. So again, Kathleen helped make that happen.

So anyway, these are a couple small steps. I mean, a thing that has happened at SAMHSA over the last year -- it got put into place the prior year but over the last year -- is being one SAMHSA. We now have a one SAMHSA approach as opposed to three centers and the OA, even competing with ourselves for time. So just as an example of that, tell me what your priorities are but show me where you put your money. The budget for my office went from $100,000 to a little over $3 million starting this year. So anyway, a lot of that $3 million -- I'll be back in L.A. soon.

(Laughter.)

MR. WEBER: Literally. But what had happened in prior years, that money was sort of diffused around the centers and just sort of doing a little good here and a little good there and the thousand flowers, thousand weeds, thousand flowers are blooming, and anyway, so over this past year,

we're about to award a number of contracts.

For example, SAMHSA had seven rather large exhibit programs for conferences. We're now going to have one, that we're working with all the centers to come up with a plan over the year, see where we need to go, and then on top of that, when there's the emergency crisis, we have to get someone somewhere, it's all in one place, just do it. That will also help us establish NASADAD.

Ever since I've been at SAMHSA and before I had gray hair, has been wanting a calendar from SAMHSA. Well, I'm using that to get the calendar for NASADAD, and once I get it, you all better use it.

(Laughter.)

MR. WEBER: People ask for stuff and then they get it and then don't know what to do with it. So I'll be calling to make sure you're using that calendar. It helps us plan, helps you plan, helps Toian plan when there are advisory council meetings, how many times Toian comes to me and it's like oh, no, we have this big meeting at the same time. So these are a couple small things.

Again, we started the centralizing which is a big thing and look forward to more input from you all about ideas, and I ask you, watch that weekly report because you will see that says when the Household Survey's coming out, that says

when DAWN's coming out, also will let you know sometimes we plan to have something out on a certain day and that'll change, but that's a good tracking mechanism for you as to what's publicly coming out of SAMHSA.

Thank you.

DR. HERNANDEZ: Barbara?

MS. HUFF: I was just going to say I read it every week, Mark, and I really appreciate getting it. I think it's really a neat thing to have and I may wait till the end of the day when it's kind of quiet and then put it up on the screen, but I think it's been very helpful. I just want to say I'm really proud of what you're doing. I've known you for a long time.

MR. WEBER: Thank you.

MS. HUFF: And I've seen humongous growth in what you do and who you are and I just want to say thank you and the fact that you got more money to do it with is wonderful, too. So anyway, thanks.

MR. WEBER: Thank you. Appreciate that truly.

DR. HERNANDEZ: I think we also need to look at having a two-way street, Mark, and see how or would it be appropriate for us to provide you with a lot of notice about, hey, we're going to do this, we're going to do that, and then be able then for you to coordinate for us in the Council, you

know, is there a point of view that Mr. Curie would like for us to express or any of the other centers, because I think there are often many times that I have been in meetings and there's no representation from SAMHSA, for example.

Having said that, maybe that's one of the ways that we as a council can participate in providing a presence, not to speak for SAMHSA, but to be able to say we are members of the Council and be able to indicate we have been in communication with Mr. Curie. He sends his regrets but he sent a check. You know, something like that.

(Laughter.)

MR. CURIE: They usually appreciate that one.

(Laughter.)

DR. HERNANDEZ: And they will appreciate that more than his presence but that's okay. But if we can also make that as a point of dialogue, where we can then communicate probably to you directly, would that be the place to do it?

MR. WEBER: That would be helpful. We're always looking for Charlie extenders and Jim Stone extenders and Beverly Watts Davis extenders, Westley Clark and Kathryn as well. Again, one of the things to helping make this work is keeping it simple, so that if you have a regular calendar that you don't mind sharing. We have weekly or every-other-week

scheduling meetings. I just take those calendars to the scheduling meeting with me, and it would be very helpful to know where other folks are going to be.

Again, I wouldn't suggest you start a big huge new system or something like that, but something that you already have available potentially electronically and you can send it in Word, WordPerfect, we'll convert it.

MR. CURIE: I want to clarify also the increase Mark received. Keep in mind much of that came from pulling together dollars that were already being spent in that area but not focused, and I think that's the important thing to realize. I don't want other people in SAMHSA to think Mark got like a better deal than anybody else, you know.

MR. WEBER: I don't need to add anything else, do I?

DR. HERNANDEZ: He'll be doing a tap dance before long.

You have the survey that we have submitted you and it's in your packet. Are there any areas that anyone would like to place their name on? I know that we talk about we all are very interested in cultural competence and cultural issues and all that. So that's kind of like cutting all across all the activities, but I found myself kind of lonely thinking about older adults.

I know that I'm probably the second senior person in this room and I can say that because I tell you what, one of my greatest heroes was Bert Pepper. There was Bert Pepper and a lady by the name of Jan Duker, another trailblazer back in the '60s. We crossed lives and Bert came in and was able to guide me in my years. I already have gray hair, he has a little more than I did.

DR. PEPPER: Now I have less.

(Laughter.)

DR. HERNANDEZ: But really, I think we need to think and today, we heard about it, the issues that Dr. Gallant indicated, older adult services, and I think that would be an area that I personally have a lot of interest and definitely would love to have companionship. Getting old and being alone is not that good.

MR. CURIE: You want to share more?

(Laughter.)

DR. HERNANDEZ: No, no. That's enough for now. That's enough for now.

MS. HUFF: I look at what I put down here and I think I must have been in a trance when I thought I could do all of this, but I am very interested in older adults, and Charlie knows I've kind of helped that older adult organization.

MS. SULLIVAN: I just passed, I just had my 50th birthday and I'm a member of NAA or whatever that thing is, AARP. I just signed up for my card.

MS. HUFF: Did you?

MS. SULLIVAN: Yes, I joined.

MS. HUFF: I did, too.

MS. SULLIVAN: And I live in Palm Desert and I should do this. In all honesty, a senior center in Palm Desert, there is no excuse, no, seriously, there is no excuse that there is a senior center to take care of me in the next 15 years in Palm Desert.

MS. HUFF: You've got to go for it, girl.

MS. SULLIVAN: And am I the youngest member of this board going on the senior committee? I just want to know.

DR. HERNANDEZ: So we've got Kathleen and Theresa.

MS. RACICOT: You know, I wrote that I had to see them. I have to see things. I'm very visual, very hands-on. But I'm really interested in that one. My mother-in-law is suffering from Alzheimer's and in assisted care. We've moved her twice in the last year. My mom, who we all thought was the 100 percent Irish happy-go-lucky, take life as it comes, I actually think my mother is dealing with some depression, and

to approach that subject with her is really, really difficult. So I really am interested in that.

DR. HERNANDEZ: Mark, do you have any update? I read something about the Older Adult Parity Act or the Older Adult something that was introduced in Congress.

MR. WEBER: I can get it. I don't have it with me.

DR. HERNANDEZ: It was something that you came across, a bill was introduced.

MS. SULLIVAN: Is this the one where the kids have to pay for their parents' medical?

DR. HERNANDEZ: No, no.

MS. SULLIVAN: I'm being serious. There is one out there.

DR. HERNANDEZ: There was one there. I was wondering. Something about older adults, that it was really interesting, but it was kind of a flash-by.

MR. WEBER: We can find out and e-mail it to you all. Just whatever we can find out. We can get a summary.

DR. HERNANDEZ: Thank you. Okay. Any other dialogues? I think Kathleen, you wanted to talk something about the L.A. prison and also you wanted material about charitable choices and Toian will get us all of information about that.

MR. CURIE: We'll be sending out all the regs and everything around charitable choice, so you can see exactly currently what the language is and the level of progress. The Executive Order as well.

MS. SULLIVAN: That'd be great. Pablo, the other day, for some reason, I've been doing great writing in the car. If I could just write this down from brain to stickshift to driving wheel. Why don't I take a run instead of spending the time here, let me take a run at writing a resolution about this county problem that I addressed yesterday or writing something down on paper?

MR. CURIE: Why don't you and Mark and myself get together and have a discussion about that as well?

MS. SULLIVAN: About the county problem?

MR. CURIE: Yes.

MS. SULLIVAN: Okay. Let's have a discussion.

MR. CURIE: I think there are some pathways.

MS. SULLIVAN: Yes. Number 2. The other thing was the L.A. County problem. I think it was Dr. Pepper who mentioned that Los Angeles County Jail is the Number 1 mental health facility in the United States. There was a big special in Los Angeles during sweeps, a five-part series with Lee Baca walking around with the most prominent newsperson in town, going through the L.A. County Jail with a lot of blame, a

blame for us, for the federal, a blame for everyone in the federal system for treatment, prevention, and mental health, and Sheriff Lee Baca is just pointing, pointing, pointing fingers for a five-part series that was on the 6:00 and the 11:00 news in Los Angeles on KNBC, the Number 1 most prominent show. Of course, he promised to follow up and they never did a follow-up.

May I mention that I think he's an opportunity? You've now got a sheriff who is pointing blame. He's now on the record. We've got some videotape. I think he's an approachable opportunity for everyone. If he is in the criminal justice system who's saying this is a problem, I don't know how to fix it, I don't have the funds, I was wondering what you all thought of the possibility of Charlie approaching some people in Los Angeles who I can help him meet and co-chairing with Lee Baca of a summit meeting, to take federal services with the county jail, prominent L.A. person and maybe is that a doable smart thing to do?

MR. CURIE: I think we have a great opportunity to be addressing that right now with the Mental Health Commission action agenda because criminal justice is one of those areas that's mentioned as well as it's appropriate also because it's in our matrix, and we had a meeting of the Mental Health Commission in L.A. and Sheriff Lee Baca came to a

reception. So I think we have a natural connect there and I think it does make sense to reach out. We went to the jail. There was a walk-through at the jail on this.
So the ground's been set with that conduit. I think we need to build on it.

MS. SULLIVAN: I would like to pursue it with anyone else and maybe we can talk. We'll discuss this again, but it was added again here first by Dr. Pepper. It usually is. It's been reiterated in Los Angeles, and I think that there is something here that SAMHSA has an opportunity as an ambassador as well for the entire federal government and you set the seeds there. So that's great to know.

MR. CURIE: Let's pursue it. That's great.

DR. HERNANDEZ: Dr. Pepper?

DR. PEPPER: Can I say goodbye now?

MR. CURIE: You can say goodbye in just a second.

DR. HERNANDEZ: Okay. We have had the opportunity to visit the resolution. Anyone that have read it yet, so we can move this item of the agenda? Okay. You have a resolution with you. We already have passed that resolution before. Yes, we kind of agreed on it.

MR. CURIE: We're just doublechecking.

DR. HERNANDEZ: We are doublechecking the field. Just want to make sure. Robert's Rules. We have to be

doublechecked all the time. That's what Mark says and I will try to remember how to say his name. I never can provide him with the right pronunciation. Weber, Weber. I don't know. Mark.

MR. WEBER: Weber.

DR. HERNANDEZ: Weber. Okay.

So we will move the resolution then to be presented to Mr. Curie. Thank you, council members, and now I would like to turn the meeting over to our chair, Mr. Curie.

MR. CURIE: Thank you, Pablo. You got a prelude of what's about to come from Bert's request and there are two individuals on this Council who, according to the law of the land, literally it's a law, it's a statute, which makes me want to make sure we don't violate it here, that once an individual has served four consecutive years on this Council, they have to take a two-year break, and there are two individuals that I would like to recognize today.

The good news is they may be at the December meeting. If there's not a replacement by then, they can continue to serve until there's a replacement, but we want to make sure that these individuals are recognized today just in case they're not back among us.

The first person I'd like to ask to join me here is Lewis. Would you please come forward? Lewis Gallant.

Lewis, I'd like to present to you a letter to express our appreciation and you'll also be receiving a framable certificate and memento for your service. So please, I'd like to recognize you. I think it's great that you were present today, too, because I think we all got a clear feel for the depth of Lewis's knowledge of not only the field, also his leadership, and while you've been on this Council, a lot of territory has been covered. You've been a part of that.

I want to recognize him particularly for bringing the workforce issues to the forefront. He's a tireless advocate to bringing that forward. Because of that, it's a permanent part of our agenda that we need to keep addressing because there's a crisis in the field. Lewis has been able to address that and articulate that on an ongoing basis.

I also want to thank Lewis for his ongoing work on the co-occurring, substance abuse, and mental illness issue. As you heard him share yesterday, that's been a contentious issue at times and yet Lewis has been consistently at the table trying to find a constructive resolution, and I've appreciated your tenure on the board.

Lewis represents obviously state drug and alcohol directors. We clearly want to keep that slot open to assure that there's still state drug and alcohol representation on this Council because it's essential because that's where the

action is, Lewis, but I just want to thank you for your tenure, for your dedicated service and for your trust.

(Applause.)

DR. GALLANT: Thank you, Charlie, and as I said yesterday, I think we have come a long way under your leadership in terms of focusing SAMHSA in a way that I think will truly benefit the field.

As I said, I've been in the field 35 years. This is the first time really that I think we have at the national level the kind of focus we need to ensure that the addict on the street is impacted by the work that goes on at the federal level and that hasn't always been the case.

When I go to work every day and I see these guys sitting in the Metro station on the grate, I say, well, how are we going to get them off? So I think with the matrix, concentrating on homelessness, concentrating on co-occurring disorders, concentrating on expanded capacity, making access and choice easier to achieve, I think that addict has a real strong possibility that he will find him or herself off the grate the next time I walk down that street.

So thank you again for your leadership and thank all the council members for all that they've been able to share with me and give me so that I can share with my members and make them even stronger as state substance abuse

authorities.

(Applause.)

MR. CURIE: Now, I'd like to ask Dr. Bert Pepper to please come forward. I'll tell you, Bert, when I first came aboard in this position, Bert was right there offering to do anything he could to help advance some real key issues. I described Bert as the Moses in the wilderness of the co-occurring. I won't say he looks like him. But I don't think it's been quite 40 years in the wilderness, probably 20.

DR. PEPPER: No, it's been 40.

MR. CURIE: Forty years. And the great news is the landmark co-occurring report to Congress. Again, Lewis participated in that. I think you had to feel that you saw some fruits to your labor to see that put forward in a way that's acknowledged by Congress as a priority, by this Administration as a priority, being embraced by the field now as a priority, that that is speaking for itself, how we need to address this issue. You were there, and I heard Kathleen and others around the table, I think you're viewed as always being ahead of your time, too, seriously, and you're not afraid to articulate that on an ongoing basis. You've been a beacon on this Council and you've been a beacon in the field, and I just want to thank you so much for your invaluable service and leadership and your support for our efforts and

give you this letter and you'll be receiving another token of appreciation, and thank you so much, Bert.

DR. PEPPER: Thanks so much.

MR. CURIE: Congratulations.

DR. PEPPER: Thank you.

(Applause.)

DR. PEPPER: Actually, it's been 45 years. 45 years ago, I got out of medical school and I went to Texas to work in a federal prison hospital with the criminal addicts. I started treating heroin addicts in Fort Worth, Texas, in a federal prison in 1958. So that's how long I've been involved with the criminal justice issue.

But to speak about the issue here, I want to thank Charlie and all of the staff and it's really interesting to work with SAMHSA because it's a curious thing. Everybody at SAMHSA has a sense of you, except Mark Weber.

(Laughter.)

DR. PEPPER: But it's really been a great experience, and I want to tell you it's been a changing experience because I owe my membership on the Council to now-deceased but memorable irascible individual named Max Schneier. Max was a member of the first SAMHSA Council and led the assault on the Administrator with regard to co-occurring disorders.

MR. CURIE: Which wasn't me.

DR. PEPPER: No, your predecessor. In fact, the Council forced the Administrator to have a national conference in 1995 on co-occurring disorders. I was the contractor at that time to write the report of the Council of the contracts, and the 1995 conference report was withheld from publication till 1998 by the prior administrator because it surfaced the topic of co-occurring disorders.

To contrast that with Charlie coming on and last year's report to Congress, a magnificent document, companion to the matrix which puts co-occurring disorders on the block, and what it really says, I come back to what my friend Lewis said a minute ago, every one of you has in your community a small number of individuals who disturb the public order, who get up every morning and they look in their pocket to see what their tickets would admit them to. Gee, I could go to jail today. Gee, I could go to the hospital today with my leg ulcer, my diabetes which is uncontrolled. I could go to a drug treatment center. I could go to a psychiatric clinic. I could go to a homeless shelter. Now what am I going to do today to mess myself up a little further and disturb the public order?

We all have such people in our community. Some of them are on the grates, some of them have used a ticket to

get into something. None of these institutions that these individuals are welcome to go to can either meet their needs or protect the community and that's the issue that we have worked together to surface to this nation and it's a continuing issue and I'm delighted that Jim Stone is here to work with you. Jim and I have worked together for 20 years, I guess.

I'm sorry that I'll be leaving some new friends on the Council, and being a shapeshifter, I promise to come back in some other incarnation. Thank you.

(Applause.)

MR. CURIE: Thank you, Bert. Thank you, Lewis. I'd like to turn it over now to Daryl Kade to invite public comment.

MS. KADE: Anyone? Is there anyone in the audience? Please, take a microphone.

MR. NORTHEY: Hi. I'm Bill Northey from the American Association for Marriage and Family Therapy, and one of the things that's arisen is trying to get the science-to-service initiative going. Most of our members -- we estimate about 47,000 marriage and family therapists -- half of them are in private practice. So getting access to training or funding, they're not Medicaid reimbursable for the most part, depending on how insurance works, they may not be

able to reimburse family therapy. So a lot of these folks aren't getting access to evidence-based models.

The other issue is that most of the evidence-based models are either proprietary, multisystemic family therapy, and to get something like that costs you $20 to $30,000 is what I'm hearing to have it implemented in some places, you know, multidimensional family therapy. Howard Little's model, he's got three or four trainers. They're out there to try to disseminate this information is really difficult and to begin to think of ways that we might -- whether it's training of trainers or in our association, we have supervision. Everybody that graduates has to get 100 hours of supervision when they graduate. So even training those supervisors to be able to use those models in ways that are effective, I think, is important.

Similarly, we know that family psychoeducation is effective for serious mental illness, but we also know that very few people get it. Marriage and family therapists are probably ideally suited to provide it. Again, they haven't gotten the training in their educational programs. They don't have access to that. So figuring out ways that we may create infrastructures to promote some of these models and to help people, in our case family therapists, who could provide some of these unique services give them opportunities to do so.

Thank you.

MS. KADE: Thank you. Any other public comments? Yes, please.

MS. WENGER: Hi. I'm Sis Wenger with the National Association for Children of Alcoholics, and there have been so many things said this morning that I wanted to react to, but I'll just pick a few.

I think for the benefit of those of you who do not know who we are, we actually are a national membership and affiliate organization that works to bring attention to the tremendous number of children of addicted parents in this country who are not getting appropriate attention or services through any of the systems where they find themselves on a daily basis and so we focus our efforts on trying to address the systems that can touch children's lives every day.

Those of you who have been around for awhile know that we worked a number of years ago with heads of all the primary care organizations that deal with families and children and with the teachers of family medicine created core competencies for primary care practitioners, they created it, we facilitated it, which were then published as a supplement to Pediatrics with a number of background research things. SAMHSA helped a great deal with that and that established a floor from which a number of things have grown kind of quietly

and that floor also has influenced the most recently produced series of recommendations called the Strategic Plan for Interdisciplinary Faculty Education. That was a jointly sponsored effort by HRSA and SAMHSA and our core competencies, you have to look for them, but they're really there making a huge difference.

So we have worked with CSAT this past couple of years in doing a similar thing with leaders of the various faith communities, the leaders who determine what faith people get in their professional training. So we have just recently -- and it's going through clearances right now -- helped these leaders develop core competencies on alcohol and drug dependence and impact on family for clergy and pastoral leaders and you will be seeing that coming out some time soon.

Today, as I listened to a number of comments made when I heard about we're referencing the trauma of two years ago, let me remind you that two years ago, we focused almost entirely on the trauma to adults and those adults who went to the bar instead of going home left unattended children whose parents came home and retraumatized them because they were intoxicated, and so we must when we are addressing these issues of trauma remember we'll have more of them tomorrow if we don't today do the things that we know how to do well to help prevent problems for these children, and I again must

thank SAMHSA for the support in developing the recently released Children's Program Kit. Some of you may have seen that or you may have seen the letter that Secretary Thompson send out to all the treatment programs in this country in which he discussed the cost and the need to address these kids' issues and what he said was "The human and economic costs of alcoholism and drug abuse are well known. Lost education, lost jobs and lost lives. For some, however, the costs are measured in the effects on family, particularly the children of substance-abusing parents."

In that letter, he urged treatment programs to begin to look at the children of their clients. Children of clients who are in treatment for mental health services benefit equally from the identical services because it is not the disease that causes the kids' problems, it's the confusion, the irresponsibility, the irrationality, the unpredictability, the emotional trauma that causes these kids to be tomorrow's depressed teenagers who become the next day's 18-to-24-year-olds developing co-occurring disorders.

So I urge you to think about the children when you're thinking about these really critical issues you're dealing with, and thanks very much.

MS. KADE: Thank you. Any other public comments?

(No response.)

MS. KADE: Very good.

MR. CURIE: Thank you, Daryl. I might mention with Sis, she talked about the Children's Program Kit. What I like is the official title she gave that, which was the Children's Program Kit. Very straightforward. But it was innovative and it's profound and I'm looking forward to getting feedback from the field because I'm hearing people are using it already and it's very important work.

I want to just conclude by again thanking each of you for taking time out of your busy schedules to invest yourself in this mission of helping build resilience and facilitate recovery for those with addictive disorders, mental illness, children and youth with serious emotional disturbances, people at risk. You heard that the burden of global disease, mental illness, mental health issues, is Number 1. Substance abuse issues, Number 2. We got to get that word out.

The Substance Abuse and Mental Health Services Administration is right in the fray of help in not only this nation but the world, and I don't think we ourselves have realized that or have thought in those terms, and I think it's important for us to keep that in mind, be mindful that what we're talking about is more than just an abstract art form which people tend to think mental health interventions and

substance abuse counseling is, but that we have data that shows treatment works and that recovery is real and we're talking about lives and we're talking about the future of this country, and I think we need to be the ones articulating that on an ongoing basis, and I thank you for being willing to be committed to this area and arena, and I'd like to now turn this over to my good friend and colleague Dr. Pablo Hernandez.

DR. HERNANDEZ: Thank you, Mr. Curie. Indeed, I will echo everything that has been said by Mr. Curie and also by you. But I want to take a moment just to recognize a couple of good friends, just good friends. I know that Bert has been around for a long time. I know that. We all know that. But he's just like a tick.

(Laughter.)

DR. HERNANDEZ: He sticks to you. He doesn't let it go. So somehow he found people like Lewis and myself and members of the Council and because of that commitment, also the same commitment that Lewis has made throughout the years, I think we really truly have moved the agenda to a whole different level. So I think in the name of the Council, both to Lewis and to Bert, we are indebted to you for your leadership to the nation and, most importantly, the leadership that you have provided and the human touch that you have

brought to persons who are addicted, to persons with mental illness and suffering from disability.

So in the name of the Council, again thank you ever so much. But we will not let you go. I mean, if you think that we will let you go away, we will find you and we will hunt you and you're still be part of our whole community and we will work together. So thank you again.

Council members, any parting thoughts of anyone? Mr. Slack.

MR. SLACK: This is timely because I didn't realize Dr. Pepper was leaving, but he said something yesterday that has stuck with me and that was in regards to public education and that perhaps what we need to do is to begin concentrating on how communities and families can show compassion, and I just had a thought a few minutes ago that what might be very interesting and hopeful to the people we serve is a President's New Freedom Commission on Compassion and where it details how communities and how families can show compassion and show respect for the people that we serve and it might go a long way in the healing process.

DR. HERNANDEZ: Thank you, Mr. Slack. I believe that we have one communication from Toian.

MS. VAUGHN: Actually, two. One is you have your orange folder and I need your reimbursement forms before you

leave, please. This is the one document that you need to sign.

Secondly, we found out that the hotel does have availability on the 11th and 12th. Arrival on the 10th. So I would ask you to tentatively hold the dates of the 11th and the 12th and as soon as we confirm the schedules with everyone, then I'll get back to you to make that permanent.

You should also know that the hotel has availability the week before Christmas which is the week of the 14th through the 17th, but I think that's going to be a little problem. So at this point in time, we're tentatively scheduled for the 10th and 11th of December.

MR. CURIE: Eleventh and 12th.

MS. VAUGHN: I'm sorry. Eleventh and 12th.

MR. CURIE: Arriving on the 10th.

MS. VAUGHN: Arriving on the 10th.

DR. HERNANDEZ: Arriving on the 10th. Thank you, Toian.

With nothing else in the agenda, do I hear a motion to adjourn?

PARTICIPANT: So moved.

DR. HERNANDEZ: We are adjourned. Thank you very much. Safe travel.

(Whereupon, at 11:05 a.m., the meeting was

adjourned.)